

Department of Health & Human Services
Centers for Medicare & Medicaid Services
61 Forsyth St., Suite 4T20
Atlanta, Georgia 30303-8909



December 27, 2010

Mr. Neville Wise, Acting Commissioner
Cabinet for Health and Family Services
Department for Medicaid Services
275 E. Main Street, 6W-A
Frankfort, KY 40621

Re: Kentucky Title XIX State Plan Amendment, Transmittal #10-008

Dear Mr. Wise:

We have reviewed Kentucky State Plan Amendment (SPA) 10-008, which was submitted to the Atlanta Regional Office on October 6, 2010. This amendment implements a statewide tobacco cessation program.

Based on the information provided, we are now ready to approve Kentucky SPA 10-008 as of December 22, 2010. The effective date is October 1, 2010. The signed CMS-179 and the approved plan pages are enclosed. If you have any questions regarding this amendment, please contact Laura Killebrew at (404) 562-0151.

While this SPA as submitted provides some tobacco cessation services for adults, including pregnant women it does not provide for all tobacco cessation services for which pregnant women are entitled to under the mandatory provisions in section 4107 of the Patient Protection and Affordable Care Act. Therefore, once CMS issues guidance on this provision, the State will be expected to submit another SPA that conforms to the provisions outlined in section 4107.

Sincerely,

A handwritten signature in black ink that reads 'Jackie L. Glaze'. The signature is written in a cursive, flowing style.

Jackie L. Glaze
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosures

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL**

FOR: HEALTH CARE FINANCING ADMINISTRATION

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

1. TRANSMITTAL NUMBER:
10-008

2. STATE
Kentucky

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE
SOCIAL SECURITY ACT (MEDICAID)

4. PROPOSED EFFECTIVE DATE
10/1/2010

5. TYPE OF PLAN MATERIAL (*Check One*):

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (*Separate Transmittal for each amendment*)

6. FEDERAL STATUTE/REGULATION CITATION:
42 C.F.R. 440.120,

7. FEDERAL BUDGET IMPACT:
a. FFY 2010 - (\$8Million)
b. FFY 2011 - (\$8 Million)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Att. 3.1-A, Page 7.2.1(C) and (D)
Att. 3.1-A, 7.5.2(a)
Att. 3.1-A, Page 7.2.1(a)(0)
Att. 3.1-B, Page 23.1 and 23.2
Att. 3.1-B, Page 31.1(a)
Att. 3.1-B, Page 22.1(a)
Att. 4.19-B, Page 20.5 and 20.5(1)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (*If Applicable*):

Same

10. SUBJECT OF AMENDMENT

This State Plan Amendment will establish reimbursement for tobacco cessation drugs.

11. GOVERNOR'S REVIEW (*Check One*):

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

☒ OTHER, AS SPECIFIED: Review delegated
to Commissioner, Department for Medicaid
Services

12. SIGNATURE OF STATE AGENCY OFFICIAL:

Neville Wise by Kevin Og-Dempsey
13. TYPED NAME: Neville Wise

16. RETURN TO:

Department for Medicaid Services
275 East Main Street 6W-A
Frankfort, Kentucky 40621

14. TITLE: Acting Commissioner, Department for Medicaid Services

15. DATE SUBMITTED: July 26, 2010

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

10/06/10

18. DATE APPROVED:

12/22/10

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

10/01/10

20. SIGNATURE OF REGIONAL OFFICIAL:

Shirley Roberts for

21. TYPED NAME:

Jackie Glaze

22. TITLE: Associate Regional Administrator

Division of Medicaid & Children's Health Opns

23. REMARKS:

Approved with following changes as authorized by State Agency on email dated 12/16/10:

Block # 7a Changed to read: FFY 2011 +1,000,000 and 7b FFY 2012 +\$825,000.

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- J. Reimbursement for induced abortions is provided when the physician certifies that the pregnancy was a result of rape or incest or the woman suffers from a physical disorder, injury or illness, including a life-endangering physical condition cause or arising from the pregnancy itself that would place the woman in danger of death unless an abortion is performed.
 - K. Any physician participating in the lock-in program will be paid for providing patient management services for each patient locked-in to him/her during the month.
 - L. Regional anesthesia (e.g., epidurals) for post-operative pain management shall be limited to one (1) service per day up to four (4) days maximum for the anesthesiologist.
 - M. Epidural injections of substances for control of chronic pain other than anesthetic, Contrast, or neurolytic solutions shall be limited to three (3) injections per six (6) month period per recipient.
 - N. Anesthesia Service limits are soft limits which means the service can be covered when medically necessary subject to prior authorization requirements described in material on file in the state agency.
 - O. Coverage for an evaluation and assessment service, provided by a physician or physician assistant with a corresponding CPT code of 99407 for tobacco cessation shall be limited to two (2) per recipient per calendar year.
 - 1. The evaluation and assessment service shall be:
 - a. Performed face-to-face with the recipient;
 - b. Be performed over a period of at least thirty (30) minutes.
 - 2. The evaluation and assessment service shall include:
 - a. Asking the recipient about tobacco use;
 - b. Advising the recipient to quit using tobacco;
 - c. Assessing the recipient's readiness to quit using tobacco products
 - d. Compiling a tobacco usage, medical, and psychosocial history of the recipient;
 - e. Incorporating a review of the recipient's coping skills and barriers to quitting; and
 - f. Providers obtaining of a signed and dated Tobacco Cessation Referral Form from the recipient declaring the recipient's intent to quit using tobacco.

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- K. Any physician participating in the lock-in program will be paid for providing patient management services for each patient locked-in to him/her during the month.
- L. Regional anesthesia (e.g., epidurals) for post-operative pain management shall be limited to one (1) service per day up to four (4) days maximum for the anesthesiologist.
- M. Epidural or spinal injections of substances for control of chronic pain other than anesthetic, contrast, or neurolytic solutions shall be limited to three (3) injections per six (6) month period per recipient.
- N. Anesthesia Service limits are soft limits which means the service can be covered when medically necessary subject to prior authorization requirements described in material on file in the state agency.
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6. Medical Care and Any Other Type of Remedial Care**d. Other practitioner's services****Advanced Practice Registered Nurse (APRN) Services**

- (1) An APRN covered service shall be a medically necessary service provided within the legal scope of practice of the APRN and furnished through direct practitioner-patient interaction so long as that service is eligible for reimbursement by Kentucky Medicaid.
- (2) APRN's participating as nurse-midwives or nurse anesthetists shall comply with the service requirements of those components for participation and reimbursement, as appropriate.
- (3) An APRN desiring to participate in the Medical Assistance Program shall:
 - (a) Meet all applicable requirements of state laws and conditions for practice as a licensed APRN;
 - (b) Enter into a provider agreement with the Department for Medicaid Services to provide services;
 - (c) Accompany each participation application with a current copy of the APRN's license; and
 - (d) Provide and bill for the services in accordance with the terms and conditions of the provider participation agreement.
- (4) Administration of anesthesia by an APRN is a covered service.
- (5) The cost of the following injectables administered by an APRN in a physician or other independent practitioner's office shall be covered:
 - a. Rho (D) immune globulin injection;
 - b. Injectable anticancer chemotherapy administered to a recipient with a malignancy diagnosis contained in the Association of Community Cancer Centers Compendia-Based Drug Bulletin, as adopted by Medicare;
 - c. Depo- Provera contraceptive injection;
 - d. Penicillin G and ceftriaxone injectable antibiotics; and
 - e. Epidural injections administered for pain control.
- (6) An outpatient laboratory procedure by an APRN who has been certified in accordance with 42 CFR, Part 493 shall be covered.

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- (7) An obstetrical and gynecological service provided by an APRN shall be covered as follows:
- a. An annual gynecological examination;
 - b. An insertion of an intrauterine device (IUD), including the cost of the device, or removal of the IUD;
 - c. The insertion of an implantable contraceptive capsule, including the cost of the contraceptive capsule and related supplies, or removal of the capsule;
 - d. Prenatal care.
 - e. A routine newborn service to an infant born to a Kentucky Medicaid eligible recipient; and
 - f. A delivery service, which shall include:
 1. Admission to the hospital;
 2. Admission history;
 3. Physical examination,
 4. Anesthesia;
 5. Management of uncomplicated labor;
 6. Vaginal delivery; and
 7. Postpartum care.
- (8) An EPSDT screening service provided in compliance with a periodicity schedule developed in conjunction with the American Academy of Pediatrics Recommendations for Preventive Pediatric Health shall be covered.
- (9) A limitation on a service provided by a physician as described in Attachment 3.1- A. pages 7.21, 7.21(a) and 7.21(a)(o) shall also apply if the service is provided by an APRN.
- (10) The same service provided by an APRN and a physician on the same day within a common practice shall be considered as one (1) covered service.
- (11) Coverage for an evaluation and assessment services with a corresponding CPT code of 99407 for tobacco cessation shall be limited to two (2) per recipient per year.
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- (b) CMS has authorized Kentucky's collection of supplemental rebates through the MMSPA.
 - (c) Supplemental rebates received by the State in excess of those required under the national drug rebate agreement will be shared with the Federal Government on the same percentage basis as applied under the national drug rebate agreement.
 - (d) All drugs covered by the program, irrespective of a supplemental rebate agreement, will comply with the provision of the national drug rebate agreement.
 - (e) Any contracts not authorized by CMS will be submitted for CMS approval in the future.
 - (f) As specified in Section 1927(b)(3)(D) of the Act, notwithstanding any other provisions of law, rebate information disclosed by a manufacturer shall not be disclosed by the state for purposes other than rebate invoicing and verification.
- (9) Tobacco Cessation
- (a) Prescription drugs

The state will provide coverage for tobacco cessation drugs that require a prescription if prescribed by a Medicaid enrolled provider authorized to prescribe drugs. Coverage will be limited to two (2) three (3) month supplies of tobacco cessation prescription drugs in a calendar year. Prior authorization is required.
 - (b) Over-the-counter drugs

The state will provide coverage for over-the-counter tobacco cessation products if prescribed by a Medicaid enrolled provider authorized to prescribe drugs. Coverage will be limited to two (2) three (3) month supplies of over-the-counter tobacco cessation drugs in a calendar year. Prior authorization is required.
- (10) Behavioral Pharmacy Management Program
- (a) CMS has authorized the state of Kentucky to enter into a contract with Comprehensive NeuroScience, Inc. (CNS), and Eli Lilly and Company (Lilly). This contract, titled "Agreement By and Among Kentucky Department for Medicaid Services, Comprehensive NeuroScience, Inc., and Eli Lilly and Company," was submitted to CMS September 5, 2006.
 - (b) Under the Agreement, Lilly will forward funds to CNS to set up and conduct a two-year Behavioral Pharmacy Management Program for the Medicaid fee for service program. CNS will utilize data to identify use of behavioral drugs that are not in line with best practices and consult with the provider. This funding will be considered in lieu of a supplemental rate and be considered as such in Kentucky's economic evaluation of the atypical antipsychotic therapeutic class for Preferred Drug List consideration. Kentucky will accept CNS services in lieu of the supplemental rebate. Kentucky will also provide data to CNS only for the purposes of these services.
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 - (8) An EPSDT screening service provided in compliance with a periodicity schedule developed in conjunction with the American Academy of Pediatrics Recommendations for Preventive Pediatric Health shall be covered.
 - (9) A limitation on a service provided by a physician as described in Attachment 3. I-B, pages 21, 22 and 22.1(a) shall also apply if the service is provided by an ARNP.
 - (10) The same service provided by an APRN and a physician on the same day within a common practice shall be considered as one (1) covered service.
 - (11) Coverage for an evaluation and assessment services with a corresponding CPT code of 99407 for tobacco cessation shall be limited to two (2) per recipient per year.
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Agency: Kentucky

MEDICAID PROGRAM: REQUIREMENTS RELATING TO PAYMENT FOR COVERED
OUTPATIENT DRUGS FOR THE CATEGORICALLY NEEDY

Citation (s)	Provision (s)
1927(d)(2) and 1935(d)(2)	<p><input type="checkbox"/> (g) covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee (see specific drug categories below)</p> <p><input checked="" type="checkbox"/> (h) barbiturates</p> <p><input checked="" type="checkbox"/> (i) benzodiazepines</p> <p>(The Medicaid agency lists specific category' of drugs below)</p> <p>Kentucky Medicaid will cover all nonprescription drug categories for full benefit dual eligible beneficiaries, which is consistent with Kentucky's policy of covering all nonprescription drug categories for non-dual recipients. Herbal products are not covered.</p> <p><input type="checkbox"/> No excluded drugs are covered.</p> <p><input checked="" type="checkbox"/> (j) agents when used to promote smoking cessation</p>

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State Agency: Kentucky

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TN No.: <u>10-008</u> Supersedes TN No.: <u>05-010</u>	Approval Date: <u>12-22-10</u> Effective Date: <u>October 1, 2010</u>

- (14) Supplemental payments will be made for services provided by medical school faculty physicians either directly or as supervisors of residents. These payments are in addition to payments otherwise provided under the state plan to physicians that qualify for such payments under the criteria outlined below in Part (a) of this section. The payment methodology for establishing and making the supplemental payments is provided below in Parts (b) and (c) of this section.
- a. To qualify for a supplemental payment under this section, physicians must meet the following criteria:
 1. Be Kentucky licensed physicians;
 2. Be enrolled as Kentucky Medicaid providers; and
 3. Be Medical School Faculty Physicians as defined in Att 4.19-B, page 20.3, with an agreement to assign their payments to the state-owned academic medical center in accordance with 42 CFR 447.10.
 - b. For physicians qualifying under Part (a) of this section, a supplemental payment will be made. The payment amount will be equal to the difference between payments otherwise made to these physicians and the average rate paid for the services by commercial insurers. The payment amounts are determined by:
 1. Annually calculating an average commercial payment per procedure code for all services paid to the eligible providers by commercial insurers using the providers' contracted rates with commercial insurers for each procedure code from an actual year's data, beginning with CY 2006;
 2. Multiplying the total number of Medicaid claims paid per procedure code by the average commercial payment rate for each procedure code to establish the estimated commercial payments to be made for these services; and
 3. Subtracting the initial fee-for-service Medicaid payments, all Medicare payments, and all Third Party Liability payments already made for these services to establish the supplemental payment amount. Effective January 1, 2007 all claims where Medicare is the primary provider will be excluded from the supplemental payment methodology.
 4. The supplemental payments will be calculated annually after the end of each CY using actual data from the most recent completed CY. Claims data will only be used for physicians meeting the criteria in Part (a) above. If a physician did not meet the criteria for the whole calendar year, then only the claims data that coincides with their dates of eligibility will be used in the calculation. The supplemental payments will not be increased with any trending or inflationary indexes.
 - c. Initial fee-for-service payments under Part (a) of this section will be paid on an interim claims-specific basis through the Department's claims processing system using the methodology outlined elsewhere in this state plan. The supplemental payment, which represents final payment for services, will be made as four (4) equal quarterly payments.
- (15) A second anesthesia service provided by a provider to a recipient on the same date of service shall be reimbursed at the Medicaid Physician Fee Schedule amount established by the Department.
- (16) A bilateral procedure shall be reimbursed at one hundred fifty (150) percent of the amount established by the Department.
- (17) A fixed rate of twenty-five (25) dollars for anesthesia add-on services provided to a recipient under age one (1) or over age seventy (70).
- (18) Physicians will only be reimbursed for the administration of immunizations, to include the influenza vaccine, to a Medicaid recipient of any age. Vaccine costs will not be reimbursed.
- (19) The department shall reimburse a flat rate of seventy-two (72) dollars per office visit for an office visit beginning after 5:00pm Monday through Friday or beginning after 12:00pm on Saturday through the remainder of the weekend.
- (20) Deep sedation of general anesthesia relating to oral surgery performed by an oral surgeon shall have a fixed rate of \$150.
- (21) For an evaluation and management service with a corresponding CPT of 99214 or 99215 exceeding the limit outlined in Att. 3.1-A p. 7.2.1 & Att. 3.1-B p. 21, DMS will reimburse any such claim as a CPT code 99213 evaluation and management visit.
- (22) The evaluation and management services with a corresponding CPT of 99201-99205 and 99211-99215 have been enhanced from approximately fifty-seven (57) percent of Medicare allowable to eighty-seven and one half (87.5) percent of Medicare allowable

- (23) For an evaluation and assessment service with a corresponding CPT of 99407 for tobacco cessation, the Department will pay a fixed fee of \$52.03 for a physician. For the same services performed by a physician assistant or an APRN, the Department will pay 75% of the physician fee.

D. Assurances. The State hereby assures that payment for physician services are consistent with efficiency, economy, and quality of care and payments for services do not exceed the prevailing charges in the locality for comparable services under comparable circumstances.